Medicare Dual Eligible Prescription Drug Coverage Act of 2005

Introduced by Senator Jay Rockefeller and Congressman Tom Allen

Background on Dual Eligibles

The Medicare Modernization Act of 2003 (P.L. 108-173) created a Medicare drug benefit for all of its beneficiaries, including 6.4 million beneficiaries who also qualify for full Medicaid because they are low-income or have high health care spending. These "dual eligibles" are among the most vulnerable of our nation's citizens. They are disproportionately women and minorities and live alone or in nursing homes. Over half of all elderly dual eligibles are limited in activities of daily living and, in comparison to other Medicare beneficiaries, they are much more likely to have heart disease, pulmonary disease, diabetes, or Alzheimer's.

The Medicare Part D prescription drug benefit begins on January 1, 2006. Rather than having Medicaid fill in the gaps of this benefit, the law creates a means-tested, low-income drug benefit. For those beneficiaries now eligible for Medicaid, it eliminates premiums for low-cost prescription drug plans (PDPs) and allows only nominal cost sharing for those drugs on the formulary. Additional low-income beneficiaries with income below 150 percent of the poverty level and assets below a certain limit qualify for less generous assistance. While the protections in the law appear comprehensive, implementation of the law could result in a reduced benefit for dual eligibles.

The Problem

There is no overlap between Medicaid and the Medicare prescription drug benefit for dual eligibles. Federal Medicaid payments for dual eligibles' prescription drugs are prohibited on and after January 1, 2006, the first day of the Medicare drug benefit. The loss of Medicaid prescription drug coverage will occur regardless of whether or not duals have obtained coverage through a Part D prescription drug plan and regardless of whether or not their Part D plan covers the drugs they are taking under Medicaid.

Dual eligibles are given less time to enroll in Medicare Part D than other Medicare beneficiaries. Medicare beneficiaries who are not dually eligible for Medicaid have 6 months to transition to Medicare Part D. Yet, the law only requires a six-week transition period for dual eligibles, from November 15, 2005, to January 1, 2006. Moving a large number of seniors and people with disabilities to an entirely new system for prescription drug coverage is a major undertaking. In its June 2004 report to Congress, the Medicare Payment Advisory Commission (MedPAC) suggested that even large, private employers need at least six months to transition their employees' drug coverage from one pharmacy benefit management company to another. The two large employers that MedPAC studied had 25,000 and 75,000 employees, respectively. The states and the federal government are taking on a far more complex task with 6.4 million duals.

Automatic enrollment will not solve the problem entirely. In the final Medicare regulations, the Centers for Medicare and Medicaid Services (CMS) indicated that they will begin to automatically enroll dual eligibles in PDPs, starting in October 2005. While this is a step in the right direction, it will not solve the problem entirely. Dual eligibles are hard to reach and auto enrollment does not guarantee that beneficiaries will know that they have been enrolled in a new Medicare drug plan or know how to access necessary prescription drugs using that drug plan. The attached report from the Medicare Rights Center, entitled "MMA and Dual Eligibles: A Transition in Crisis" (http://www.medicarerights.org/MMA_Duals.pdf) gives several examples of beneficiaries at-risk even with automatic enrollment in a PDP.

Once enrolled, dual eligibles will still need assistance managing the new Medicare prescription drug program. In addition to the challenges in the change in enrollment, dual eligibles will have to manage a change of systems. There are likely to be misunderstandings about formularies, restricted access to pharmacies, and cost containment protocols like "fail first" in which one drug must be tried before a more expensive one is covered.

The "clawback" creates a disincentive for states to enroll more dual eligibles. Because of the clawback formula, the fewer dual eligibles that a state signs up, the less it pays in clawback payments.

The Solution

In order to guarantee that no low-income senior or disabled individual will experience gaps in prescription drug coverage, the Medicare Dual Eligible Prescription Drug Coverage Act would:

- **Extend the availability of Medicaid prescription drug coverage for six months while still allowing the Part D benefit to be implemented as scheduled.** A transition period of six months gives dual eligibles time to explore their options and to gradually transition to Medicare Part D.

- **Delay implementation of state "clawback" payments to the federal government for six months.** States would be fully relieved of any clawback responsibilities during the transition since they would be temporarily supplementing Medicare Part D.

- **Provide dedicated resources for education and outreach to the dual eligibles.** Of the $1 billion that has already been appropriated to the Centers for Medicare and Medicaid Services (CMS) for administrative costs, $100 million would be specifically directed toward education and outreach efforts to the dual eligibles, at least $20 million of which would go to State Health Insurance Assistance Programs (SHIPs).

- **Require CMS to share drug utilization data with state Medicaid programs.** State Medicaid programs are still responsible for providing health coverage for the duals beyond prescription drugs, and they will need drug utilization data in order to appropriately coordinate care.